

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESFORM APPROVED
OMB NO. 0938-0351STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

445294

(X2) MULTIPLE COMPLETION

A. BUILDING

B. WING

(X3) DATE SURVEY
COMPLETED

06/07/2012

NAME OF PROVIDER OR SUPPLIER

LIFE CARE CENTER OF COLLEGEDALE

STREET ADDRESS CITY, STATE, ZIP CODE

PO BOX 858, 9210 APISON PIKE
COLLEGEDALE, TN 37315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	<u>Life Care Center of Collegedale</u>	
F 272 SS=D	<p>During the annual Recertification survey and complaint #29834 investigation conducted on June 4, 2012, through June 7, 2012, at Life Care Center of Collegedale, no deficiencies were cited related to the complaint.</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum</p>	F 272	<p>Preparation of and/or execution of this plan of correction does not constitute admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because of federal and state requirements.</p> <p>1. CORRECTIVE ACTION- F272</p> <p>Resident # 200 Assessment revised on June 5, 2012 by the Minimum Data Set Nurse.</p> <p>2. OTHER RESIDENTS THAT HAVE THE POTENTIAL TO BE AFFECTED</p> <p>On June 22, 2012 a review of the last 14 days of submitted assessments was conducted by the Minimum Data Set Nurse(MDS), for accuracy of events data to include falls.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

445284

(X2) HAS THE CORRECTION

A. YES

B. NO

(X3) DATE SURVEY
COMPLETED

06/07/2012

NAME OF PROVIDER OR SUPPLIER

LIFE CARE CENTER OF COLLEGE DALE

STREET ADDRESS, CITY, STATE, ZIP CODE

PO BOX 555, 2210 APISON PIKE

COLLEGE DALE, TN 37315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	<p>Continued From page 1</p> <p>Data Set (MDS); and</p> <p>Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review and interview, the facility failed to complete an accurate comprehensive assessment for one (#200) of forty sampled residents reviewed.</p> <p>The findings included:</p> <p>Resident #200 was admitted to the facility on April 23, 2012, with diagnoses including Aftercare Trauma Fracture of Pelvic, Hypertension, Anxiety, Depressive Disorder, and Alzheimer's Disease.</p> <p>Medical record review revealed on April 23, 2012, at 10:50 p.m., the resident sustained a fall receiving a small skin tear to the right elbow.</p> <p>Review of the Minimum Data Set (MDS) fifteen day assessment dated May 5, 2012, and the thirty day MDS assessment dated May 19, 2012, revealed the MDS did not reflect the fall on April 23, 2012.</p> <p>Interview with MDS (Minimum Data Set) Coordinator #1 in the MDS office on June 6, 2012, at 10:50 a.m., confirmed the completed MDS dated May 5, and MDS dated May 19, 2012, had been coded incorrectly and did not reflect the</p>	F 272	<p>3. WHAT MEASURES WERE PUT IN</p> <p>On June 21, 2012 the Minimum Data Set (MDS) Nursing Staff were educated by the Director of Nursing to review nurses notes and attendance of clinical meetings to ensure that pertinent information is obtained for entry into the minimum data set.</p> <p>To ensure accuracy the MDS Nurse will attend clinical meetings daily and weekly events meeting.</p> <p>The Director of Nursing (DON) will audit 2 Minimum Data Sets per week for 3 months to ensure accuracy of assessment.</p> <p>4. MONITORING</p> <p>The Director of Nursing will report the MDS audit findings monthly to the Performance Improvement Committee.</p>	<p>COMPLETION DATE June 30, 2012</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PROVIDER/CLIA IDENTIFICATION NUMBER

FORM APPROVAL

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445284	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/07/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COLLEGE DALE			STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 658, 9210 APISON PIKE COLLEGE DALE, TN 37315		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 272	Continued From page 2	F 272			
F 280 SS=D	<p>resident's fall.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to update the Care Plan to address weight loss for one resident (#45) of forty residents reviewed.</p> <p>The findings included: Resident #45 was re-admitted to the facility on November 18, 2010, with diagnoses including Parkinson's Disease, Anemia, Alzheimer's</p>	F 280	<p>1. CORRECTIVE ACTION- F280</p> <p>On June 23, 2012 Minimum Data Set (MDS) Coordinator and MDS nurse were educated by the Director of Nursing on the policy for updating resident care plans.</p> <p>2. OTHER RESIDENTS THAT HAVE THE POTENTIAL TO BE AFFECTED</p> <p>On June 23, 2012 the MDS Coordinator and MDS nurse conducted a review of resident care plans identified by the Registered Dietician during the month of May and June to ensure weight loss interventions were included.</p> <p>3. WHAT MEASURES WERE PUT IN</p> <p>Resident # 45 care plan was revised on 5/30/12 by the MDS nurse then reviewed on 6/23/12 to ensure all interventions for weight loss were included.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445284	(X2) MULTIPLE CERTIFICATION PLAN A. DEFENSE B. WING	(X3) DATE SURVEY COMPLETED 69/07/2012
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COLLEGE DALE	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 658, 5210 APISON PIKE COLLEGE DALE, TN 37315
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F 280	<p>Continued From page 3</p> <p>Disease, Gastroesophageal Reflux, Cardiomegaly, and Vitamin deficiency.</p> <p>Medical record review of the Minimum Data Set (MDS) dated February 9, 2012, revealed the resident had severe cognitive impairment, required extensive assistance with all activities of daily living, and weighed 138 pounds.</p> <p>Medical record review of the Care Plan dated February 16, 2012, revealed "...res) has some missing natural teeth...At risk for weight loss...Regular diet w/chopped meats, no sandwiches..."</p> <p>Medical record review of the Weight Change History report dated January 1, 2012 through June 6, 2012 revealed "...2/1/2012 137.80 (pounds); 3/2/12 138.60; 4/3/12 110.60; 4/6/12 110.6 ...6/1/12 111.0..."</p> <p>Medical record review of a Nutrition Data Collection/Assessment dated April 7, 2012, revealed "...current weight 110.6...IBW (ideal body weight) 112 - 138...significant wt change...add to NIP (Nutrition Intervention Program) to follow...no wounds...unintended wt. (weight) loss r/t (related to) possible decrease po (oral intake) in evening...follow wkly (weekly) wts...add to NIP...consider iron supplement after CBC (Complete Blood Count) this month...Rec (recommend) Ensure Pudding BID (twice a day)...placed on NP (nurse practitioner) board..."</p> <p>Medical record review of the Care Plan revealed no new interventions or recommendations by the Registered Dietician were added to the Care Plan until May 31, 2012.</p>	F 280	<p>To ensure continued accuracy the MDS Coordinator/Nurse will attend clinical meetings daily, and weekly nutrition meetings. In addition they will review the nutrition meeting log to monitor resident weight changes and ensure care plans are updated weekly with changes.</p> <p>The Director of Nursing (DON) will review 5 Care Plans per week for 3 months to ensure accuracy of updates.</p> <p>4. MONITORING</p> <p>The Director of Nursing will report the findings of the care plan review to the Performance Improvement Committee monthly for 3 months.</p>	COMPLETION DATE June 30, 2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM A-100-1
OMB NO. 0938-0361

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

445284

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

(X3) DATE SURVEY
COMPLETED

06/07/2012

NAME OF PROVIDER OR SUPPLIER

LIFE CARE CENTER OF COLLEGE DALE

STREET ADDRESS CITY, STATE, ZIP CODE

PO BOX 658, 9210 APISON PIKE
COLLEGE DALE, TN 37316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 4	F 280	1. CORRECTIVE ACTION- F311	
	Interview with the Director of Nursing on June 7, 2012, at 10:10 a.m., in the conference room confirmed the Resident's care plan was not updated in April 2012 when the weight loss was noted.		As of 6/7/12 Resident #125 continued on her restorative plan per physician order by the Restorative Nursing Assistant.	
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS	F 311	2. OTHER RESIDENTS THAT HAVE THE POTENTIAL TO BE AFFECTED	
	A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.		On June 11, 2012 the Restorative Nurse was educated by the Regional Director of Clinical Services on the process of receiving referrals from therapy and processing of new programs and physician orders.	
	This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure restorative nursing was provided for one (#125) of forty residents reviewed.		On June 11, 2012 the Physical Therapist, the Restorative Nurse and the Regional Director of Clinical Services reviewed all current and pending restorative orders.	
	The findings included:		Orders were verified and Restorative Certified Nursing Assistant (C.N.A.) educated by the Restorative Nurse on the importance of timely initiation of a new program.	
	Resident #125 was admitted to the facility on February 4, 2012, with diagnoses including Hypertension, Arthritis, Depression, and Urinary Tract Infection.		3. WHAT MEASURES WERE PUT IN	
	Medical record review of a physician's order dated May 17, 2012, revealed "...Restorative Nursing PT (physical therapy)...6 days wk (week) x 8 wks...ambulation/gait training, OT (occupational Therapy)...6 days wk for 4 wks...therapeutic exercises."		To ensure accuracy the Director of Nursing will attend the weekly Restorative meeting.	
	Medical record review of the Nursing Rehabilitation/Restorative Care Daily Flow Sheet dated May 20, 2012, revealed Restorative			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PROVIDER/CLIA
IDENTIFICATION NUMBER
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A45264	(X2) MULTIPLE CORRECTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/07/2012
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NAME OF PROVIDER OR SUPPLIER

LIFE CARE CENTER OF COLLEGEDALE

STREET ADDRESS, CITY, STATE, ZIP CODE
PO BOX 658, 8210 APLISON PIKE
COLLEGEDALE, TN 37315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 5 Nursing had not been initiated until May 23, 2012 (6 day delay from date of order on May 17, 2012). Medical record review of the Nursing Rehabilitation/Restorative Care Daily Flow Sheet dated May 27, 2012, revealed the resident received Restorative Nursing on May 27, 2012, and not again until June 3, 2012. Interview on June 6, 2012, at 12:55 p.m. with the Director of Nursing, in the conference room, confirmed a delay in starting restorative nursing and restorative nursing had not been provided 6 days a week as ordered by the physician the week of May 27, 2012.	F 311	The Restorative Nurse will receive additional corporate training by 6/30/12 to ensure complete understanding of the program. The Director of Nursing (DON) will audit the referral form from the therapy department by logging the date of referral and the date of initiation.	
F 371 SS=F	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to serve food to residents under sanitary conditions. The findings included: Observation on June 4, 2012, at 12:10 p.m., in	F 371	4. MONITORING The Director of Nursing will report results of the audit to the Performance Improvement Committee monthly for 3 months. 1. CORRECTIVE ACTION- F371 On June 4, 2012 staff were immediately given instruction by the Registered Dietician to contain hair while serving in the dining room.	COMPLETION DATE June 30, 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465294	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/07/2012
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COLLEGEDALE	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 658, 9210 APISON PIKE COLLEGEDALE, TN 37315
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F 371	Continued From page 6 the main dining room, revealed four staff members with uncontained shoulder length hair serving the noon meal to residents. Interview with the Registered Dietician on June 4, 2012, at 12:13 p.m., in the main dining room, confirmed the four staff members with uncontained long hair were serving residents under unsanitary conditions and their hair was to be contained.	F 371	2. OTHER RESIDENTS THAT HAVE THE POTENTIAL TO BE AFFECTED Staff were educated on June 21, 2012 by the Staff Development Coordinator and the Director of Nursing to ensure all staff assisting in the dining room have hair contained.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441	3. WHAT MEASURES WERE PUT IN On June 21, 2012 the hair containment education was added to new associate orientation by the Staff Development Coordinator. The Registered Dietician or designee will monitor meals in the dining room to ensure serving staffs hair is contained for 4 weeks or until 100% compliant. 4. MONITORING The Registered Dietician will report the observations of monitoring at the monthly PI meeting for 3 months.	COMPLETION DATE June 30, 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445294	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/07/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COLLEGEDALE			STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 658, 9210 APISON PIKE COLLEGEDALE, TN 37316		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 441	<p>Continued From page 7</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, observation, and interview, the facility failed to maintain infection control for one random observation during a medication pass.</p> <p>The findings included:</p> <p>Observation on June 5, 2012, at 8:20 a.m., with Licensed Practical Nurse (LPN) #1 revealed LPN #1 administered Novolog Insulin 3 units subcutaneous to the resident's left abdomen without wearing gloves.</p> <p>Review of facility policy, Subcutaneous Injection, revealed "...Observe (standard) universal precautions or other infection control standards...wear gloves when appropriate..."</p> <p>Interview on June 5, 2012, with LPN #1 confirmed gloves are to be worn when giving an injection.</p>	F 441	<p>1. CORRECTIVE ACTION- F441</p> <p>On June 21, 2012 Nurse #1 was educated by the Staff Development Coordinator on the policy for wearing gloves during administration of injections.</p> <p>2. OTHER RESIDENTS THAT HAVE THE POTENTIAL TO BE AFFECTED</p> <p>On June 21, 2012 the nursing staff were educated by the Staff Development Coordinator on the policy for wearing gloves during administration of injections.</p> <p>3. WHAT MEASURES WERE PUT IN</p> <p>On June 21, 2012 100% of the nursing staff were educated on the policy for wearing gloves during administration of injections.</p> <p>The policy for wearing gloves during administration of injections was added to the new associate orientation by the Staff Development Coordinator.</p> <p>The Staff Development Coordinator will conduct 10 random observations weekly for 3 months.</p>		
F 502 SS=D	<p>483.75(j)(1) ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The</p>	F 502			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION(A) PROVIDER/PRN/PERMITS
IDENTIFICATION NUMBER

(C) MULTIPLE CONSTRUCTION

A. LUNING

B. WING

FORM APPROVED
CMS NO. 0938-02

DATE SURVEY
COMPLETED

445234

06/07/2012

NAME OF PROVIDER OR SUPPLIER

LIFE CARE CENTER OF COLLEGE DALE

STREET ADDRESS, CITY, STATE ZIP CODE
PO BOX 658, 9240 ARISON PIKE
COLLEGE DALE, TN 37316

(X2) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	<p>Continued From page 8</p> <p>facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review and interview, the facility failed to obtain laboratory services as ordered for one resident (#45) of forty residents reviewed.</p> <p>The findings included:</p> <p>Resident #45 was re-admitted to the facility November 18, 2010, with diagnoses including Parkinson's Disease, Anemia, Alzheimer's Disease, Gastroesophageal Reflux, Cardiomegaly, and Vitamin deficiency.</p> <p>Medical record review of Physician Orders dated June 1, 2012, revealed "...CBC (complete blood count), CMP (complete metabolic profile) every 3 months (JAN/APR/JUL/OCT) 10/25/10 (date originally ordered)..."</p> <p>Medical record review of the laboratory reports revealed a CBC and a CMP were completed in January 2012. Further medical record review revealed no documentation the labs for April 2012 were completed as ordered.</p> <p>Interview with the Nurse Consultant on June 6, 2012, at 3:45 p.m., at the 200 Hall Nurse's Station, confirmed the laboratory studies, CBC and CMP, were not completed as ordered in April 2012.</p>	F 502	<p>4. MONITORING</p> <p>The Staff Development Coordinator will report the findings of the observations to the Performance Improvement Team monthly for 3 months.</p> <p>1. CORRECTIVE ACTION- F502</p> <p>On 6/7/12 a stat lab was obtained for Resident #45 and reviewed by physician, no new orders were received.</p> <p>2. OTHER RESIDENTS THAT HAVE THE POTENTIAL TO BE AFFECTED</p> <p>An audit of all resident labs was conducted on 6/22/12 by the Director of Nursing, and the Unit Managers to ensure physician orders were followed.</p> <p>3. WHAT MEASURES WERE PUT IN</p> <p>The Unit Managers will be responsible for auditing labs on a weekly basis for 4 weeks then monthly to ensure they are completed.</p> <p>The Director of Nursing will monitor the Lab Audits for 3 months.</p> <p>4. MONITORING</p> <p>The Director of Nursing will report the audit findings to the Performance Improvement Team monthly for 3 months.</p>	<p>COMPLETION DATE June 30, 2012</p>